

**MINNESOTA BOARD OF PHARMACY**

2829 University Avenue SE #530  
Minneapolis, Minnesota 55414

**STATE OF MINNESOTA**

## **CANCER DRUG REPOSITORY PROGRAM NOTICE OF PARTICIPATION OR WITHDRAWAL**

Completion of this form meets the notification requirement for participation in, or withdrawal from, the Cancer Drug Repository Program under Minnesota Statute 151.55. Complete and submit this form to the following address. Questions about completing this form may be directed to 651-201-2825. This form must be maintained for at least five years

Minnesota Board of Pharmacy  
Cancer Drug Repository Program  
2829 University Avenue SE #530  
Minneapolis, Minnesota 55414  
**OR FAX TO**  
612-617-2262

<b>NOTICE OF PARTICIPATION PHARMACY OR MEDICAL FACILITY</b>
---

A pharmacy or medical facility may fully participate in the cancer drug repository program by accepting, storing and dispensing donated drugs and supplies or may limit its participation to only accepting and storing donated drugs and medical supplies. Check one of the following:

☐ Full Participation (Will dispense drugs and supplies.)      ☐ Partial Participation (WILL NOT dispense drugs and supplies.)

Name -- Pharmacy or Medical Facility	Telephone Number
--------------------------------------	------------------

Address
---------

City	State	Zip Code
------	-------	----------

Name -- Pharmacist	License Number	Telephone Number
--------------------	----------------	------------------

I certify that the above named facility is licensed in the State of Minnesota and is in compliance with all State and Federal laws and administrative rules.

<b>SIGNATURE -- Pharmacist</b>	Date Signed
--------------------------------	-------------

<b>NOTICE OF WITHDRAWAL PHARMACY OR MEDICAL FACILITY</b>
--

Name -- Pharmacy or Medical Facility	Telephone Number
--------------------------------------	------------------

Address
---------

City	State	Zip Code
------	-------	----------

As of (enter date) \_\_\_\_\_ the pharmacy or medical facility identified above, will no longer be participating in the Cancer Drug Repository Program.

<b>SIGNATURE -- Pharmacist</b>	Date Signed
--------------------------------	-------------